BoardRoom Press

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Investing in Health

I just got my bivalent Omicron booster today, giving me a new sense of optimism about the road ahead when it comes to COVID. Optimism these days is hard, when the new news is around how much less healthy we Americans are because of delays in care while we waited out the pandemic. I talk to my children about the things that are within our control when it comes to health (e.g., eating "growing food" and exercising for good health) and things that are not as much (cancer, car accidents).

Healthcare providers are also facing a period of relative decline in health: sicker patients, a workforce crisis, and increasing financial constraints. Boards may not be in control of financial challenges, but they are in control of their fiduciary fulfillment. We need to come back to the (in-person) boardroom table reengaged in strategy and thinking about the future. Strong themes emerged from our September Leadership Conference and Governance Support Forum in Colorado, the most important being that effective governance is crucial right now. Board education and comprehensive oversight now and going forward will be at its most critical level as "back to normal" activities resume, including and especially a more urgent level of legal and regulatory scrutiny.

Fall is a time of reflection and anticipation of what is to come in the new year. With this issue of *BoardRoom Press*, we bring reasons for boards to renew their optimism—to engage and invest in their organization's health alongside investments in our patients' and communities' health, and most importantly, a fresh focus on the future.

Kathryn C. Peisert,
Editor in Chief & Senior Director

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Sharpening Precision in Matters of Strategy, Risk, and Financial Sustainability

By Reese Jackson, J.D., FACHE, Chesapeake Regional Healthcare

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Healthcare delivery, like baseball, is in many respects a team sport, especially in highly competitive markets. To win is to execute. "Close only counts in horseshoes and hand grenades," said Frank Robinson, Major League Baseball player and manager in a 1973 issue of *Time* magazine.

Reese Jackson, J.D., FACHE
President and CEO
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When healthcare leaders and their boards assess strategic and operational opportunities requiring an investment of time, expertise, and money, the opportunity at hand is often modeled with a pro forma and evaluated after implementation. It's not always easy to be accurate. While being "directionally correct" is better than the alternative, sharpening precision in matters of strategy, risk, and financial sustainability is key.

Prior to making an investment, an opportunity is often revealed as part of a planning effort. Therefore, strategic planning is the first step in sharpening precision. In other words, "planning drives budget drives operations."

Executing Strategy

Growth is the necessity of reinvention. With ever-increasing expenses, growth, whether by acquisition, service-line expansion, or other means, is traditionally the major focus of a strategic plan. After all, marginal revenue typically exceeds marginal cost. And given the choice, it's much preferable to add volume than to cut expense.

Strategic plans, cyclical over three-to-five-year horizons, are a great mechanism for focusing your organization on growth and other vital pillars. Bringing together key stakeholders—board members, physicians, business partners—is an opportunity to create and recreate a shared vision for your organization outwardly and inwardly.

The strategic planning process requires serious introspection and a review of market dynamics and competitive position. It also includes being honest about the organization's underlying financial condition, looming pressure points, and the "cash gap" (quantified through five-year financial modeling) that must be closed to make ends meet. This is particularly important for healthcare providers because they are both capital and labor intensive.

Create a strategic operational plan. The outcomes of a strategic planning effort cannot be singularly about growth. Operational excellence falls on management "in the here and now." The importance of daily operations, real-time problem-solving, interdependence, and teamwork are vital to an organization's longevity. Without focused, agile, and committed "operators," the strategic plan is worthless.

Clinical quality improvements, measurements of patient, physician, and employee satisfaction, reduction of premium pay, payer negotiations, supply chain initiatives, and revenue cycle improvement are all important to close the cash gap and cannot be ignored. The best strategic plan is segmented into annual operational plans or strategic operational plans using pillars such as safety and quality, people, finance, growth, and community.

The executive team, prior to formulating annual capital and operating budgets, updates the five-year financial model (the cash gap schedule) and annual strategic operational plan. The annual plan becomes the predicate for board approval and is most effective when physicians, board members, and other stakeholders are included in its review and formation.

Unite and conquer. While senior executives are accountable for strategic and operational initiatives, middle management is more heavily involved in their execution and must be engaged and empowered to enact change.

One way of doing this is to host a day retreat, break out into teams with assigned leaders, and have each group create tactical plans for selected initiatives. Ideally the organization has a project manager responsible to establish rapport with team leaders and work with the executive team on a quarterly basis to review and track progress toward goal attainment.

Key Board Takeaways

To sharpen precision, work with the CEO and executive team to:

- Every three to five years, reassess the strategic plan with an accompanying cash gap schedule; updates should be made as needed in the interim years.
- Ensure that the annual capital and operating budgets are tied to a strategic operational plan.
- Monitor the key metrics and ratios that ensure clinical and financial success.
- Challenge executives to perform at the highest level and to take calculated risks.

Addressing Risk

"When the well is dry, we know the worth of water." In keeping with this quote from Benjamin Franklin's *Poor Richard's Almanack,* it is important to bear in mind that capital allocations are how bets are placed between strategic pursuits and operational needs. Generally, the annual capital budget is equal to depreciation plus one-half of operating income.

The formulaic, capital budget includes projects arrayed by category—strategic, clinical, information technology, and facilities—with minimal or no contingency. To smooth cash flow, the annual capital budget is further allocated by quarter in near equal amounts. Most every item over $500,000 should require a business plan (i.e., a reliable cost accounting system with internal experts that can produce valid pro formas and business plans) and unplanned capital expenditures require a substitute.

In essence, be disciplined and don't let the well run dry.

Take what the market gives you. At times, opportunities present themselves that are too good to pass up. Time is on your side, so run with it and identify a capital substitute, even if it means you stretch other important priorities to future years. Ensure that the investment is consistent with the strategic plan, has a positive internal rate of return and net present value, and is implemented with a detailed action plan.

Ensuring Financial Sustainability

Foster trust with business literacy. The strategic planning cycle repeats, beginning anew with an updated

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Human Stories: COVID Lessons on the Importance of Family Presence

By Sherry B. Perkins, Ph.D., RN, FAAN, Luminis Health Anne Arundel Medical Center

Early in the pandemic there was complexity and ambiguity across our nation's hospitals about COVID transmission and how to keep our healthcare teams safe. This was compounded by PPE (personal protective equipment) guideline confusion and shortages such as masks, gowns, and goggles. The response to this was the elimination of family presence in hospitals. Luminis Health Anne Arundel Medical Center, which has embraced full 24-7 access for patients' families since 2010, found the COVID-19-related visitor restrictions to be disruptive and harmful. In collaboration with the Institute for Patient- and Family-Centered Care (IPFCC), we adopted processes to facilitate the integration of patient, family, and community partners in the planning and decision making to reaffirm and reestablish a patient's family as partners, not visitors.

Building on a long history and culture of caring, in 2010 we formally oriented our practice to patient- and family-centered care models. Patient- and family-centered core concepts include respect and dignity, information sharing, participation, and collaboration.[1] Our hospital was an early leader in the Better Together: Partnering with Families program.[2]

The 2010 work began with patient and family advisors (PFAs), initiation of a patient family advisory council (PFAC), and elimination of visiting restrictions. The goal of patient and family advisors is to systematically engage with leaders and staff and hold a mirror to your organization. This work expanded to specialty patient family advisory councils (PFACs) with focus in women and children, behavioral health, emergency care, cancer care, and partnership with our Latinx community. At times, our work has been driven through appreciative inquiry and building on what is working well. Other work has been driven from a problem orientation and seeking to address concerns.

This partnership and family presence is shown to improve many aspects of care experience, safety, and quality.[3] The key practice is recognizing family members as partners, rather than visitors or external members in care. Lack of family presence contributes to patient and family harm and caregiver distress. Family presence is linked to reduced falls, infections, readmissions, excess utilization, care inequities, and caregiver distress, and improved patient experience and access. Improvements in these constructs align with the seminal STEEEP definition of quality: safe, timely, effective, efficient, equitable, and patient-centered.[4]

With this more than 10-year journey and noted benefits, the abrupt and volatile COVID-19-driven changes in family presence were deeply felt in our hospital.[5] Research studies have demonstrated the impact of these policies on rates of delirium and sedation, ICU length of stay, falls, and psychological trauma and moral distress.[6] We determined the need for a systematic approach to welcome families back to the hospital. Our approach was grounded in PFCC principles and a bioethical decision-making model.[7] The team was led by the hospital President and comprised of direct care providers and community members. Lessons learned included recommitment to family presence as evidence-based and inherent to our values and culture; a renewed understanding of the harm to patients, families, and care teams with limited family presence; and the need for a systematic and sustainable approach to drive family presence improvements. We continue to apply the systematic framework we developed to advance our family presence practices.

Key Board Takeaways

- Patient- and family-centered care (PFCC) improves quality and health system financial outcomes. Family presence thrives within a PFCC infrastructure supported by PFAs (patient family advisors), PFACs (patient family advisory councils), executive leadership, medical staff, and the board.
- COVID-19 resulted in a major disruption to family presence due to healthcare team workload, infection transmission concerns, and personal protective equipment availability.
- The absence of family presence during the pandemic highlighted its importance and harm to patients, families, and the healthcare team.
- Family presence can be systematically returned to pre-pandemic practices.
- Board members can strategically drive PFCC practices in the same fashion they drive other improvements: understand results, variances, and action plans, and hold management accountable for improvement.

"Nothing about Me without Me"

The key difference in patient- and family-centered care models is that care is organized through the principles of respect and dignity, information sharing, participation, and collaboration. This partnership yields work focused on "nothing about me without me" and caring "with" and not simply "for or to."[8] Care practices include open family presence or visiting hours, bedside shift reports, and access to electronic medical records.

More importantly, this model is supported by a foundation that begins with governance practices at the board level that drive leadership structures and processes. The PFACs advise the board

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1 Institute for Patient- and Family-Centered Care (IPFCC), "Patient- and Family-Centered Care Defined" (Web page).
2 Learn more about this IPFCC program at www.ipfcc.org/bestpractices/better-together.html.
3 Daniela J. Lamas, "Families Are Central to Critical Care. But the Waiting Room Is Empty," *The New York Times,* August 17, 2020.
4 Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century,* National Academies Press, 2001.
5 Sherry B. Perkins, Ph.D., RN, FAAN, et al., "Family Presence During COVID-19: Learning from One Hospital's Journey," *NEJM Catalyst,* June 22, 2022.
6 See e.g., T.S. Valley, et al., "Changes to Visitation Policies and Communication Practices in Michigan ICUs during the COVID-19 Pandemic," *American Journal of Respiratory and Critical Care Medicine,* Vol. 202 (2020); pp. 883–885; T.K. Gandhi, "Don't Go to the Hospital Alone: Ensuring Safe, Highly Reliable Patient Visitation," *The Joint Commission Journal on Quality and Patient Safety,* Vol. 48 (2022); pp. 61–64.
7 Deborah L. Dokken, M.P.A., et al., *Family Presence During a Pandemic: Guidance for Decision-Making,* Institute for Patient- and Family-Centered Care, 2021.
8 Michael J. Barry and Susan Edgman-Levitan, "Shared Decision Making—The Pinnacle of Patient-Centered Care," *The New England Journal of Medicine,* 2012.

Physician Recruitment in the Era of Virtual Care: To Buy or Not to Buy?

By Susan Corneliuson, Guidehouse, and Guy M. Masters, M.P.A., Masters Healthcare Consulting

With ambulatory patient volumes returning to or exceeding pre-pandemic volumes, demand for physicians is accelerating. However, this increased demand is colliding headfirst with a declining and disengaged workforce that puts greater pressure on hospitals and health systems to recruit, engage, and retain their physician workforce. A study by Jackson Physician Search reported that 54 percent of physicians surveyed indicated that they planned to make an employment change as a result of COVID-19, with 36 percent of those individuals considering retirement or leaving the practice of medicine altogether.[1]

Further, rising out-of-pocket costs, economic uncertainties, and the proliferation of healthcare innovators and innovations is changing consumer preferences about how they engage and manage their health and the health of their families. According to a study conducted by The Commonwealth Fund, consumerism is driving health systems to pursue greater and more connected ambulatory and digital footprints and to reimagine the consumer healthcare experience.[2]

Furthermore, the proliferation of private equity dollars into the provider healthcare landscape (e.g., acquisition of medical groups and ambulatory surgery centers) along with non-traditional players is strengthening the strategic and economic rationale for health systems to acquire additional physicians across specialties to ensure adequate supply to capture market share and preserve patient volumes.

Future-forward boards and their management teams are reframing the healthcare conversation to create environments of care that reinvigorate the practice of medicine and engage consumers where they are at. This article explores strategic considerations for boards in regards to provider access and growth, and the key features of the automated healthcare delivery system of the future, as well as how these two components together have the potential to set the stage for a successful recruitment and retention strategy.

Evaluating Access: Considerations for a Recruitment Strategy

The three pillars of long-term growth include network, patient, and provider access. These pillars should be routinely monitored by the board and evaluated by management as an essential first step in determining an effective recruitment strategy as follows.

Network Access

Network access requires maintaining and growing membership in existing markets, growing new markets and network partnerships, and expanding services, populations, and channels to meet community needs. Organizational boards and their management teams should be able to answer questions such as:

- What is your investment per provider by location?
- What services do you provide?
- What patients are you serving or plan to serve?
- What market forces are impacting your ability to grow?

Key Board Takeaways

- Employing physicians will be more costly and difficult than ever. What network, patient, and provider strategies are you actively deploying to meet these challenges?
  - » Do you have a clear provider network access strategy that links recruitment decisions with geographic contribution margin and market trends?
  - » Can your patients, their families, and caregivers obtain meaningful and timely healthcare in a manner that is convenient for them and meets their needs?
  - » Do you have an effective APP workforce strategy in place to reduce cost and drive access?
- Does your organization have an effective retention strategy with an evolved environment of care that reinvigorates the practice of medicine?
  - » Have you unlocked hidden capacity in your operational and clinical care processes? What opportunities exist to move the needle?
  - » Are you adopting technology and hyperautomation at a pace that will allow you to win at the recruitment game?
  - » Are inefficiencies and repetitive processes reduced and/or eliminated using technology, automation, and standardized processes?

Exhibit 1: Addressing Key Dynamics

There are dynamics causing significant shifts in care delivery that health systems must address.

Key Health System Dynamics	Care Delivery Takeaways
1 The **physician–patient relationship** is fundamentally evolving	1 Deploy a multi-tiered primary care strategy that uses **virtual care and APPs** to create scale at a lower cost
2 Price transparency and the continued emphasis on value creates **more pressure on margin**	2 **Automate repetitive care processes** to maximize capacity, workforce retention, and efficiency
3 **Patients will own their medical record** and leverage more choice in how they engage for care	3 Deploy a **consumer-centric care approach** that empowers patients to actively engage with their care team
4 **Digital solutions and technology enablement are core essentials**, no longer a differentiator	4 Use convenient **digital tools and communication channels** to meet consumers needs and expectations

1 Tony Stajduhar, *On the Verge of a Physician Turnover Epidemic*, Physician Recruitment Survey Results, February 2021, Jackson Physician Search.
2 Anna D. Sinaiko, Elizabeth Bambury, and Alyna T. Chien, *Consumer Choice in U.S. Health Care: Using Insights from the Past to Inform the Way Forward*, The Commonwealth Fund, November 2021.

This framework creates a strategic outlook of service capabilities from in-person to virtual care options to ensure that care aligns with consumer needs while further determining what the current and projected revenue expectations are per member or geographic contribution margin. Addressing these baseline questions will allow the management team to more effectively use limited resources to make the right recruitment choices in the right locations.

Patient Access

Patient access is the second fundamental component of a provider recruitment strategy. Patient access is defined as the ability of patients and their families and caregivers to obtain meaningful and timely healthcare in a way that meets their needs. For the board, this involves understanding the patient population for whom they are responsible or have chosen to serve and creating a snapshot of both current and potential future patients. Identifying and segmenting patient populations by key demographic and market factors as well as how they currently engage or want to engage with the healthcare system sets the stage for designing the right setting and processes to provide the right care at the right time. It is essential to identify what the board's priorities are for the healthcare system (e.g., convenience, access, provider relationship, continuity of care), how their patients want to engage with the healthcare system and provider (e-visits, urgent care, face-to-face visits, mobile app), and how their patients want to communicate (email, text, phone, patient portal, in-person).

Identifying who the patients are and what they desire helps to tailor the care model design requirements while bringing to light areas of opportunity and provider network gaps. For example, a large Medicare Advantage population in a particular market will require clinics focused on senior care and providers with skill sets in internal medicine and geriatric care. In contrast, a large healthy commercial population will require ease of access, same-day appointments, virtual care, and a robust compliment of primary care advanced practice providers (APPs) and physicians.

It is also important to track and monitor network retention to ensure that a closed-loop referral process is in place to create consumer stickiness and improve care coordination. A recent study in *Health Affairs* found that increasing patient activation and engagement in care can reduce costs and contribute to improved health outcomes, including clinical indicators, healthy behaviors, and preventative screenings.[3]

Identifying and segmenting patient populations by key demographic and market factors as well as how they currently engage or want to engage with the healthcare system sets the stage for designing the right setting and processes to provide the right care at the right time.

Provider Access

Finally, it is important to continuously take stock of existing provider access and capacity levels, maximizing the supply of provider services through optimization of existing employed and managed provider resources and internal support systems. In the past, management teams have traditionally responded to access challenges by adding new physicians instead of first unlocking the capacity of existing resources. Increased competition for providers is making it no longer feasible for organizations to hire their way out of these patient access problems and cost constraints are making it an untenable option for many health systems.

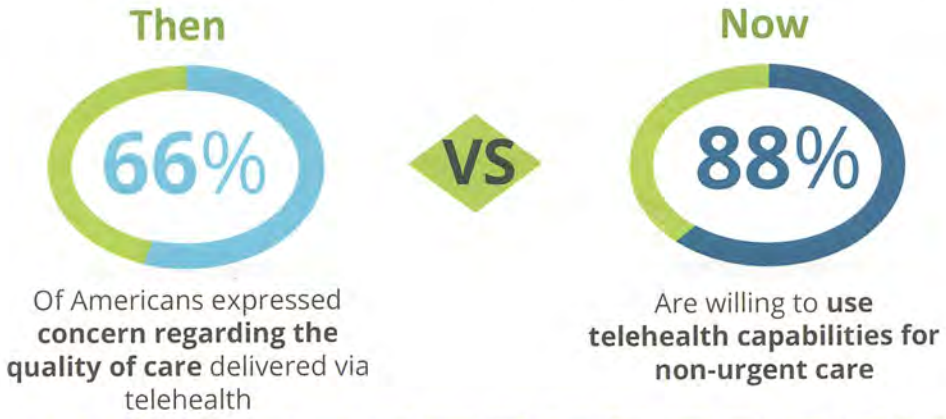
According to a survey by Merritt Hawkins, patient wait times for a primary care appointment are averaging 24 days.[4] Yet the average scheduling fill rate for primary care physicians is 78 percent, indicating a large gap in demand vs. available untapped capacity.[5] The scheduling fill rate industry-wide for a high-performing medical group is 90 to 95 percent; therefore, on average, organizations are performing at 10 to 15 percentage points below the target benchmark. Implementing specialty-specific scheduling guidelines and template management criteria can unlock unused appointment slots while increasing capacity without adding additional costs.

Boards should evaluate their organization's APP workforce strategy as a key component of a recruitment strategy and as a way to reduce or minimize costs while scaling growth in primary and specialty care. Many management teams are escalating the growth of their APP workforce, recognizing the benefits of a higher physician to APP ratio including improved quality of care, increased

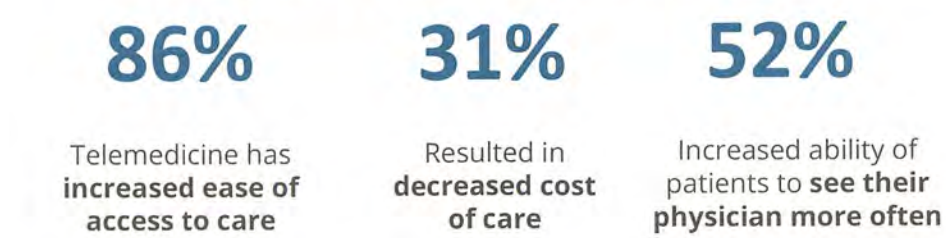
3 Jessica Greene, et al., "When Patient Activation Levels Change, Health Outcomes and Costs Change, Too," *Health Affairs,* March 2015.
4 *2017 Survey of Physician Appointment Wait Times,* Merritt Hawkins Team, September 22, 2017.
5 Nikhil Sahni, et al., *The Productivity Imperative for Healthcare Delivery in the United States,* McKinsey Center for US Health System Reform, McKinsey & Company, February 2019.

Exhibit 2: Consumer Perceptions of Telehealth

How Feelings About Telehealth Have Changed Over the Course of the Pandemic



Reported Benefits of Telehealth Use



Source: Sykes, "How Americans Feel About Telehealth: One Year Later," 2021.

patient access, enhanced provider experience, and reduced financial cost. In many cases, health systems are moving to a 1:3 or even 1:4 ratio of physicians to APPs. This increased interest in APPs by competitors will continue to challenge organizations who are further behind in implementing a comprehensive APP access solution.

> Use of APPs in the primary care setting for medically complex patients reduces acute care services and total cost of care. A 6 to 7 percent lower case-mix adjusted total cost of care was reported for diabetic patients seen by a physician assistant or nurse practitioner than those seen by a physician.[6]

With APP scope of practice restrictions lifting or being enhanced across the country, many organizations are looking to primary care APPs to serve as independent practitioners to increase access or as extenders to manage busy practice panels or to increase capacity for same-day appointments, acute visits, or follow-up appointments. From a specialty perspective, APPs working at the top of license can free up physician time to perform necessary procedures and surgeries while providing more time for the care team to engage with the patient around education, and avoidance of surgical complications and infections. Furthermore, virtual APP hubs are being established as part of the digital backbone supporting more innovative models of care.

Evolving Care Models: Considerations for a Retention Strategy

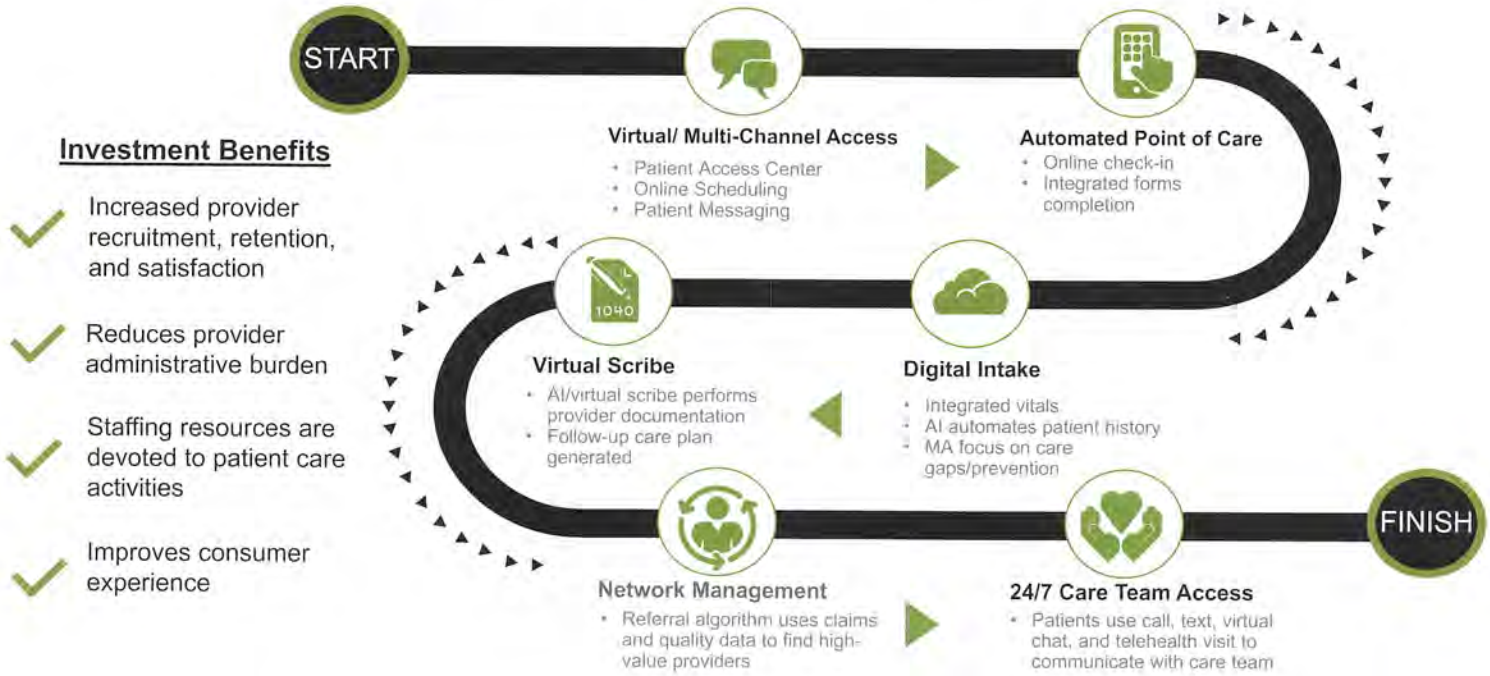
Determining the three pillars of access—network, patient, and provider—sets the stage for a comprehensive recruitment strategy, including identification of network retention gaps, provider recruitment needs, and existing capacity optimization. Boards should next ensure the organization has an effective retention strategy and environment of care that reinvigorates the practice of medicine and engages consumers where they are at with evolving models of care.

Future-forward management teams are advancing the connection between

6 Perri A. Morgan, et al., "Impact of Physicians, Nurse Practitioners, and Physician Assistants on Utilization and Costs for Complex Patients," *Health Affairs*, June 2019.

Exhibit 3: Benefits of Automation

Create Market Differentiation and Provider and Consumer Stickiness through Automation



virtual and in-person care, meeting patients where they are at. Consumers are more receptive to virtual care because of the pandemic and feel that more care can be handled virtually given the right infrastructure, including remote patient monitoring, non-urgent physician consultations, and warm hand-offs to in-person care.

Given the great resignation, challenges in recruiting primary care and specialists, clinic workforce shortages, and employee preferences for remote/flexible work, management teams should focus on retention strategies that integrate both virtual and in-person capabilities. While virtual care is not for everyone and every situation, it can serve as an essential component to coordinated healthcare delivery.

While physician recruitment and retention may be more important now than ever before, traditional approaches to improving operational and clinical workflows are not suited to today's needs. Maturing digital health business models and hyper-automation is rapidly reshaping healthcare, making it no longer a parallel or optional path but a critical one. Hyper-automation aggregates tools and technologies to reduce repetitive tasks freeing up limited resources, thereby allowing physicians and their care teams to spend more time with patients. Hyper-automation saves time, reduces errors, and standardizes operational and clinical processes.

> Creating efficiencies by translating paper process into an electronic environment is no longer relevant. Workflows need to be automated with redundancies and repetitive processes eliminated to solve ever-evolving workforce challenges and create greater joy in the practice of medicine.

A recent survey conducted by Stanford Medicine found that nearly half of physicians and three-quarters of medical students are pursuing training in areas such as population health, coding, and advanced statistics, while one-third are studying artificial intelligence (AI). Furthermore, more than 40 percent of physicians, medical students, and residents feel that healthcare could be transformed by personalized medicine, AI, and telemedicine over the next five years.[7] This trend will result in a greater number of physicians out of residency and fellowships with expectations for and experience in advanced tools and technologies both from an operational and clinical perspective. Organizations that are adopting these technologies at a faster pace will have a greater opportunity to win at the recruitment game.

Automation Is No Longer Optional

The new automated healthcare delivery organization recognizes that implementing integrative digital solutions across modalities improves clinical processes while increasing patient engagement and experience. The idea is to move from a static, paper-like, reactive model of care to a dynamic, proactive model of team care, enabling providers to treat more complex patients along the care continuum. In the 2021 *Internet of Healthcare Report*, 92 percent of clinicians identified administrative work as a major contributor to burnout, while more than half of administrative staff reported an increase in manual

7 *Stanford Medicine 2020 Health Trends Report, The Rise of the Data-Driven Physician.*

data entry in the past 12 months.[8] A separate study by the Council for Affordable Quality in Healthcare (CAQH) determined that roughly 40 percent of administrative support tasks (i.e., eligibility verification, copay collection, documentation, billing, and collections) could be automated with a potential savings of $29.84 per each patient encounter.[9]

Creating efficiencies by translating paper process into an electronic environment is no longer relevant. Workflows need to be automated with redundancies and repetitive processes eliminated to solve ever-evolving workforce challenges and create greater joy in the practice of medicine.

Future-Forward Perspective

Provider recruitment, especially primary care, in an expanding era of virtual care is an essential board tool for a successful competitive growth strategy. The strategy must also identify the following key elements:

- **Geographic contribution margin**: Understand network, patient, and provider adequacy and geographic contribution margin to establish the right path to recruitment from both a fee-for-service and value perspective.
- **APP workforce strategy:** Evaluate the medical group's APP workforce strategy to reduce or minimize costs while scaling growth in primary and specialty care.
- **Innovative and automated care models:** Implement integrative digital solutions across modalities to improve clinical processes while increasing patient engagement and experience.

Boards and their management teams that will be successful in this future environment must:

- Prepare for competition for physicians and other clinical staff to intensify as demand increases for these resources from sources other than hospitals and health systems.
- For health systems that currently employ physicians, anticipate and recruit prospectively to attract, engage, and retain these individuals by providing them a "most preferred" workplace setting that allows them to thrive by being productive, engaging in meaningful work, and having the tools, technology, and other resources to meet a diverse range of patient types and needs. This includes virtual and in-person capabilities, timely (immediate) referrals, one-stop shopping, accelerated results, and seamless transitions of follow-up care.
- Address the financial aspects of continuing to employ physicians to ensure that associated costs are as low as possible, losses are minimized, and production is optimized through a coordinated approach to resources, focused on providing the right care to meet the patient's need, at the right time, in the appropriate setting, in-person, virtual, or otherwise.

The ideal future state will be an environment of care that optimizes patient access, convenience, and confidence, while coordinating the appropriate level of clinical resources and personnel that are recruited to diagnose, treat, and resolve efficiently and effectively any need that presents itself to the satisfaction of everyone involved. Technology, training, experience, and other resources must be balanced and integrated to continue to achieve better care and outcomes consistently to meet the needs of patients and the communities served.

The Governance Institute thanks Susan Corneliuson, Director, Healthcare, Guidehouse, and Guy M. Masters, M.P.A., President, Masters Healthcare Consulting and Governance Institute Advisor, for contributing this article. They can be reached at scorneliuson@guidehouse.com and guymasters11@gmail.com.

8 *Internet of Healthcare Report, Findings Summary Q4 2021,* Wakefield Research.
9 *2020 CAQH Index®: Closing the Gap: The Industry Continues to Improve, But Opportunities for Automation Remain.*

A Covenant Management Playbook for Challenging Times

By Matt Robbins and Robert Turner, Kaufman, Hall & Associates, LLC

The COVID-19 pandemic has created an exceptionally difficult environment for hospitals and health systems. Although we have hopefully moved beyond the "crisis" phase of the pandemic, as described below, new challenges have emerged as we move into the "stabilization" phase.

Financial Performance Deteriorates as Economy Responds to Crisis Measures

We are working our way through three stages of the pandemic:

- **The crisis stage**: This began in March 2020 and stretched through 2021. It was a time of extreme operational disruption for hospitals and health systems. From a financial perspective, it was largely a monetary event, marked by major federal stimulus spending (approximately $5 trillion total) and an accommodative monetary policy from the Federal Reserve, which saw its balance sheet swell from just over $4.2 trillion in March 2020 to more than $8.9 trillion early in 2022.[1]
- **The stabilization stage**: This is where we are today. Thus far, this stage has been characterized by a renewed focus on—and growing concern with—the financial performance of hospitals and health systems. From a financial perspective, it is a credit event, as the economy responds to the crisis phase, the policy choices made, and the various outcomes. The economic response includes surging inflation for both wages and supplies, tightening monetary policy and rising interest rates from the Federal Reserve, and market volatility.
- **The normalization stage**: Signs that we have achieved normalization will include a stable workforce environment, a stable interest rate environment, and a return to steady financial performance and capital spending. Reaching this stage will be driven largely by the ability of the Fed and policy makers to bring inflation under control, but also by the performance improvement efforts of health systems.

Key Board Takeaways

As the board is apprised of potential covenant issues and plans to mitigate them, key questions include:

- How significant is the gap in financial performance that is threatening a covenant breach? Does leadership see that gap as a short- or long-term issue?
- What levers can leadership pull to mitigate the impact of poor financial performance? What will be the impact of pulling those levers on the organization's long-term sustainability and strategic direction?
- How long does leadership think it will take to stabilize financial performance? What assumptions or uncertainties might affect that estimate?
- Are there other potential covenant issues in the longer term if stabilization of financial performance takes longer than estimated? What can leadership do now to manage those issues proactively?

As shown in **Exhibit 1**, hospitals and health systems were hit hard as they entered the stabilization stage, with severe financial losses for many in the first months of 2022. Financial performance has been undermined

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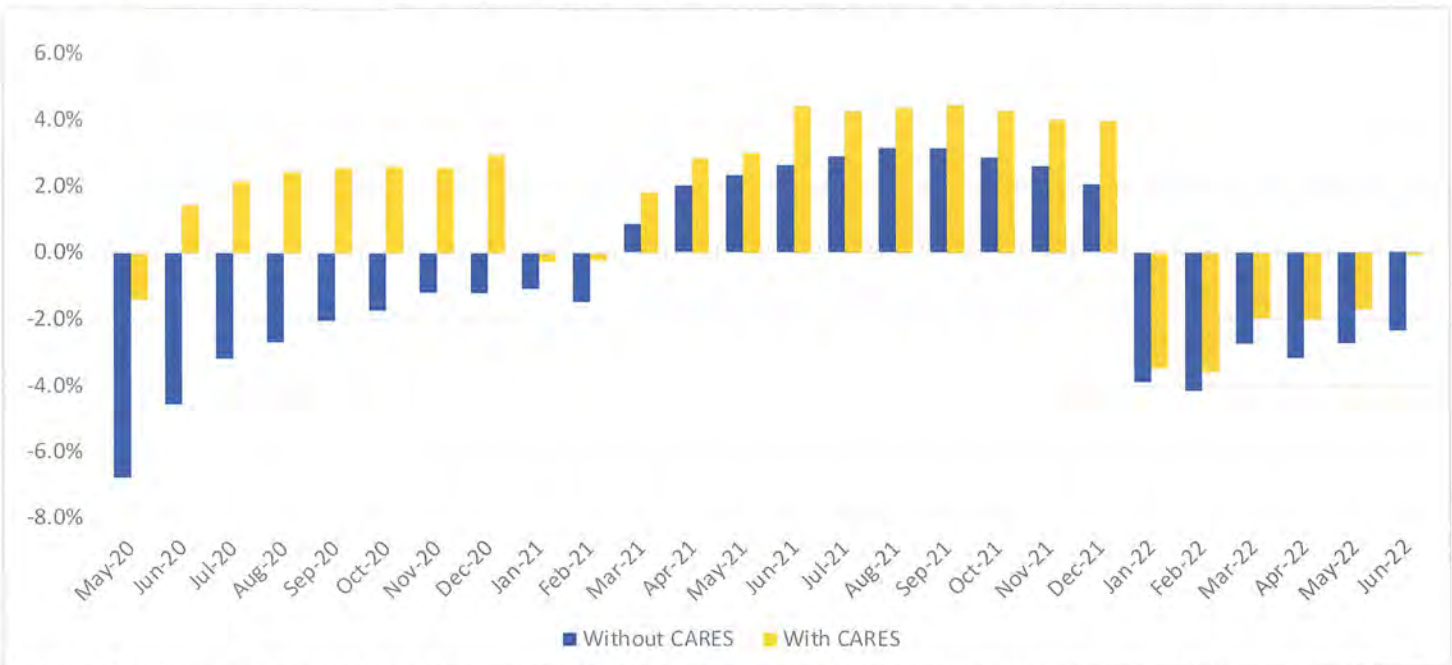
Exhibit 1: Kaufman Hall Operating Margin Index, YTD by Month (May 2020–June 2022)



Source: Kaufman, Hall & Associates, LLC. The Kaufman Hall Hospital Operating Margin and Operating EBITDA Margin Indices are comprised of the national median of our dataset adjusted for allocations to hospitals from corporate, physician, and other entities.

1 Board of Governors of the Federal Reserve System (U.S.), "Assets: Total Assets: Total Assets (Less Eliminations from Consolidation): Wednesday Level (WALCL)," retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/WALCL, July 28, 2022.

Sharpening Precision...

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three-to-five-year plan (and accompanying cash gap schedule). To effectuate results, however, requires more than a periodic meeting of the minds. In particular, the executive team must be aligned, strategically and operationally, with its governing board, management team, and medical staff and employees. Focusing on business literacy by tracking and sharing high-level metrics for utilization (growth), operating efficiency, revenue cycle management, and debt capacity using key metrics and ratios will create overall understanding and foster trust.

Quality eats strategy for lunch. While growth, vision, and strategy are all important, they all originate from the core mission to deliver safe and effective medicine. And frankly, a focus on safety and clinical quality boosts the bottom line and attracts and retains customers. The focus on safety and clinical quality reduces errors, readmissions, and length of stay, and includes the standardization of work and clinical protocols. Its pursuit is the highest form of sharpening execution, as it is the pursuit of perfection—no preventable harm, zero defects.

Conclusion

In many respects, sharpening precision is the pursuit of perfection. Perfection is a goal, a largely unattainable goal, and one that cannot be achieved much less pursued without dedication, passion, and teamwork. The best way to sharpen precision is to harness everyone's collective talents with a strategic operational plan, then constantly measure, evaluate, and adapt to meet the needs of customers with quality and safety at the forefront.

The Governance Institute thanks Reese Jackson, J.D., FACHE, President and CEO, Chesapeake Regional Healthcare, for contributing this article. He can be reached at reese.jackson@chesapeakeregional.com.

A Covenant Management Playbook...

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by such factors as surging expenses, staffing shortages that have affected volumes and revenue, and declining liquidity, driven by market losses and repayment of loans received under the Medicare Accelerated and Advance Payment programs in the pandemic's early months. The result is a median operating margin that has remained in negative territory through the first half of 2022. With the impact of the CARES Act fading, and no further government support for hospitals and health systems on the horizon, 2022 is shaping up to be the worst of the past three years.

For many organizations, these circumstances put them at risk of breaching covenants related to financial performance in their bond documents. These covenants might include debt service coverage, days cash on hand, or maintenance of a minimum credit rating (e.g., Baa3 or BBB-). Board members must understand the risk their organizations face, and the steps required to manage a potential covenant breach effectively.

A Covenant Management Playbook

The most important thing to understand is that breach of a covenant may allow creditors to demand immediate repayment of the debt. If a covenant breach is a possibility, the organization's leadership should immediately engage counsel and its advisors to organize efforts in response. A few basic steps can help form a playbook to manage potential covenant issues. Organizations should:

1. Understand the key financial covenants in their Master Trust Indenture (MTI) and credit agreements and determine whether amendment or waiver of those covenants should be pursued with creditors, including bondholders and credit banks.
2. Develop detailed performance plans that identify:
   - Key drivers of the breach
   - Near- and long-term strategies and tactics to improve financial performance
   - The organization's plan to measure, monitor, and execute its performance improvement plans
3. Integrate performance improvement plans with financial planning to articulate improved financial performance.
4. Measure, monitor, and communicate results proactively to key stakeholders.

Board members should be among the first stakeholders to be apprised of potential covenant issues and of the plans leadership is developing to manage these issues (see sidebar on page 10 for key questions the board should ask). Other stakeholders include the organization's full management team, rating agency analysts, credit banks, and bondholders. This playbook becomes the communication tool for maintaining credibility with various internal and external stakeholders until the stabilization phase transitions to the normalization phase.

Planning for Long-Term Sustainability

Even if an organization successfully manages to avoid a potential covenant breach, leadership and the board should take the potential breach as a sign that more attention must be given to ensuring the organization's long-term sustainability. Planning to avert the immediate crisis should shift to a long-term approach that integrates strategic planning, financial planning, partnership planning, performance improvement, and balance sheet management. We are in a period of extreme uncertainty, and the time it will take to move from stabilization to normalization is unknown. Organizations will need to bring all the resources at their disposal to bear to stay on the path to sustainability.

The Governance Institute thanks Matt Robbins, Senior Vice President, and Robert Turner, Managing Director, Kaufman, Hall & Associates, LLC, for writing this article. Matt can be reached at mrobbins@kaufmanhall.com and Robert at rturner@kaufmanhall.com.

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and senior leaders on how to make improvements to the model. PFAs have essential roles in work such as medical and nursing staff peer review, root-cause analyses, daily safety huddles, COVID-19 incident command structure, quality councils and board committees, approaches to reducing workplace violence and injury, executive job interviews, review of Web design and educational materials, hospital bill readability and transparency, patient education material, marketing and Web site content, well-being strategies, and wayfinding content and placement.

The posture expected by executives, medical staff leaders, and board members is a commitment to PFCC principles and ensuring accountability of operational leaders to implement practices and achieve results. Fundamental for me as CNO, COO, and now President has been the knowledge that I do not have to "guess" about the support of leadership as we have enacted changes. Essential to this work is connectivity of PFAs with board members. Our governance structure ensures expectations for PFCC and reporting by PFAs as members at our senior-most governance quality committee.

Aligning Our Journey with DE&I

We strive to lead on topics of anti-racism and demonstrate our commitment to diversity, equity, inclusion, and justice.[9] Our Latinx PFAC arose early in the pandemic from a community concern with family access and language barriers during the most limiting phase of family presence. When family members are present, even with a language barrier, rapport is built, care is witnessed, and trust and partnership grows. This same opportunity doesn't exist without family presence. We acknowledged this gap for family presence and the potential for disparate processes. The yield was strong with a multi-pronged effort driven through our Latinx PFAC; changes included improved interpretation, signage, care planning participation, and financial counseling.

Early in the pandemic when family presence was removed, there was an appreciated ability to "just focus on the patient" in the midst of such uncertainty. This, however, was soon followed by recognition of the clinical harms and caregiver distress generated by lack of family presence. A continued focus has been on team well-being and infection prevention, but with additional focus on support informed by trauma-informed leadership principles.[10]

Community Impact

This PFCC journey and our COVID response has resulted in the engagement of community members beyond patients and families, to the benefit of our organization, patients, families, and communities. In our most poignant example, a long-time community leader, the senior pastor in a church with majority African American membership, became a key partner in our COVID-19 response. She is very engaged in our community and serves as a trusted advisor. She was an early voice for COVID-19 vaccination and we recruited her to be part of our recommitment to family presence. She was instrumental in eliciting parishioner input and raising awareness on potential racial disparities related to family presence. She later became a board member. She describes her critical functions as being where the people are, listening to community members and connecting with management, and acknowledgement of the contribution of "outsideness" she brings with her perspective.

This example and the family presence work we are doing demonstrate the importance of developing human understanding, which is achieved when the organization has gained the ability to treat every patient as an individual. The more work we do in this area, the better healthcare leaders will be able to connect this work with higher-quality care and improved outcomes.

Why Do This? The Business Case

Board members have a responsibility to ensure that the organization's mission, vision, and values are enacted and fulfilled. In doing this, they govern performance and hold leaders accountable to many dimensions. PFCC is as essential as financial stewardship. There is a financial business case demonstrated through organizations such as ours that have strong market position with consumers, medical staff, and employees. This position comes, in part, due to sustained excellent results in quality, patient experience, and workplace environment.

Starting the conversation in the boardroom is the most important first step. Board members need to ask:

- How does a governance decision align with mission, vision, and values?
- What are the links between PFCC practices and financial performance? What can we learn from multi-dimensional indicators such as HCAHPS scores, falls, infections, patient complaints, indicators of disparities, pay-for-performance results, market share, retention of medical staff, executive recruitment, and turnover?
- How might a strategic board conversation be different if a patient or family member was in the room?
- What is the nature of patient family advisors and patient and family advisory council structure?
- What is the digital accessibility for participation in advisors work and PFACs? What is the diversity of participation and leadership in PFACs?
- How are C-suite and medical staff leaders engaged in PFAC work and systematically prioritizing, resourcing, and implementing evidence-based practices?
- In addition to the positive feedback, engagement, and insight that comes from PFAs, what are the challenges and problems the PFACs are addressing (e.g., complexity and harm noted in response to the pandemic or barriers contributing to disparities)?
- How are we individualizing care through principles of respect and dignity, information sharing, participation, and collaboration? How are frameworks such as the 4-Ms (what Matters, Medication, Mentation, and Mobility) driving to "what matters" for individualizing care?[11]

The Governance Institute thanks Sherry B. Perkins, Ph.D., RN, FAAN, President, Luminis Health Anne Arundel Medical Center, for contributing this article. She can be reached at sperkins2@luminishealth.org.

9 "Luminis Health Board of Trustees Approves and Adopts 10 Bold Health Equity, Anti-Racism Recommendations," *The Beacon*, Luminis Health, October 4, 2021.
10 Rose O. Sherman, "Using a Trauma-Informed Leadership Approach," *Nurse Leader*, June 2021; Mary Koloroutis and Michele Pole, "Trauma-Informed Leadership and Posttraumatic Growth," *Nursing Management*, December 2021.
11 Kedar Mate, et al., "Evidence for the 4Ms: Interactions and Outcomes across the Care Continuum," *Journal of Aging and Health*, February 8, 2021.

Performance Enhancement...

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Exhibit 1: Five-Pillar Performance Enhancement Framework

and protocols can drive realized value from the tangible movement in key metrics for cost and performance, such as reducing 30-day inpatient readmissions with increased care coordination at the time of discharge.

A comprehensive triage consisting of a deep analysis of an organization's current value contracts, operations, and processes inform on the potential PEOs built on transparent, repeatable, and industry-accepted approaches. Value levers in this pillar of the PE framework drive performance on VBC contracts and include:

- Reducing 30-day inpatient hospital readmissions
- Reducing emergency department (ED) and skilled nursing facility spend
- Improving coding accuracy
- Improving quality measures
- Reducing network leakage
- Managing chronic conditions

Reducing ED spend is an important lever around optimizing ER visits, where you can have capacity for the appropriate types of patients being seen, but also reduce the unnecessary visits that drive up cost. This lever indirectly helps balance the interests of a provider organization's financial and population health operations to properly blend within revenue and cost, and more broadly for smartly balancing provider participation within FFS and VBC models.

As seen in **Exhibit 2**, a vendor deployed a PE effort for a management services organization (MSO) helping providers uncover value within their 30-day readmissions. Utilizing the appropriate value lever from the first pillar, the MSO realized substantial decreases of 19 to 39 percent from baseline to final readmission rates (yearly).

This decrease was realized across the MSO's Medicare NextGen ACO, Medicare Advantage, and MSSP contracts. It resulted in a performance enhancement of more than $3.3 million in two years—solely by effectively lowering 30-day readmissions and ED costs, through a select group of protocol participants. Additional benefits—in the form of improved care quality and outcomes—are realized when patients in this type of PE effort avoid the hospital and ER. Note the year-over-year increases on ROI. This happens from the optimization of best practices, as well as increased protocol participation across a wider number of plans, involving more individuals and addressing more operational workflows.

As seen in **Exhibit 3** on the next page, A medium-sized health system ran two value levers from the operations program (pillar 1). This resulted in the provider organization realizing just over $1.25 million in value by reduced 30-day readmissions and decreasing ED spend.

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Exhibit 2: Case Study of MSO 30-Day Readmissions

	2020			2021		
	NextGen	Medicare Advantage		MSSP	NextGen	Medicare Advantage
Baseline readmission rate	16.80%	14.00%		14.30%	16.20%	14.60%
Final readmission rate	13.30%	11.40%		8.70%	12.50%	11.20%
Percentage improvement	21%	19%		39%	23%	23%
ROI	3.0	2.7		4.5	3.6	3.9

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Exhibit 3: Case Study: Health System with Reduced ED Spend, Readmissions, and More Annual Wellness Visits

Total value realized and opportunity, $K

1. **Reduce 30 day readmits** by ~43% in the intervened populations in 2021, generating $860K in value.
2. **Reduce ED spend:** Reduced total cost of care by 84% in CMS and 34% in commercial populations, 1 month following intervention.
3. **Improve AWV:** Captured an additional 1,355 AWV's with an estimated $142K in FFS and operational efficiency gains.

innovaccer

The first value lever run, for 30-day readmissions in a transitional care management protocol, led to $860,000 of realized value and $364,000 or 42.3 percent of potential realized value. This specific lever was run across two different hospital groups in the health system, further refined through a select number of patients assigned, who were insured by Medicare or a single specific commercial plan.

The second value lever run, for reducing ED spend, reduced the total cost of care by 84 percent in CMS populations and 34 percent in commercial populations, in just one month after running the recommended protocol. The provider recognized nearly $400,000 in performance enhancement, and $2.1 million of realized value with program expansion.

Through effective protocol deployment through the framework, health professionals come to not only realize value, but often see a significant spread between realized and potential realized value. A difference that points to all that is being left on the table if they were to have maximized the recommended protocol usage.

It's a big reason why the use of an effective PE vendor often starts small and continues to grow throughout application across different parts of a healthcare organization.

Pillar 2: Contract Performance Revenue

The value levers within this pillar apply to live PEOs for providers, delivered through a bookends approach throughout the measurement period with payers in a value-based contract.

The front end of this approach focuses on contract negotiations and the back end reflects on live efforts applied within performance dispute resolutions. And because those effectively utilizing PE should have experience working on both sides of the provider-payer contract, they will be familiar with where to find extra money and opportunities.

For example, a common challenge experienced by providers in value-based contracts occurs when payers incorrectly attribute patients, ICD truncations, and quality gaps when reconciling payer performance. Here, the organization synthesizes claims experience to find opportunities for carve-outs. They also equip clients—providers or vendor MSOs—with a shadow file gap analysis, contract methodology check, and regional benchmark data, to check against payers on reported results.

Pillar 3: Revenue Enhancement to Fund Population Healthcare Infrastructure

This pillar connects into the VBC operations program (pillar 1) by measuring transactional revenue outcomes under FFS, while contributing to value-driven performance. Value levers relating to services—including annual wellness visits and initial preventive physical examinations, transitional care management, chronic care management, remote patient monitoring, advanced care planning, and referral management—help keep revenue in the system, as well as driving appropriate care.

Though not often being the largest contributor to dollars saved, this pillar and its levers bring value through

increasing patient connection to the system. Specifically, by helping to improve patient–provider trust and relationships, closing potential care gaps, and adding revenue that may lead to total cost of care savings.

Case Study: Growing Annual Wellness Visits

Utilizing PE efforts through PEO, a private, not-for-profit network of community and specialty hospitals, with a hard-to-reach population, increased the employment of annual wellness visits across a population of 10,000 patients. Apart from an increase in revenue, this lever drives greater coordination with patients on:

- Noting/scheduling screening appointments
- Identifying risk factors for present and future health
- Reviewing current providers and prescriptions
- Optionally, addressing advanced care planning

Pillar 4: Vendor Optimization

A recent report from Morning Consult revealed that 97 percent of healthcare executives are making digital transformation a key focus area. Greater investments will be made into data readiness and interoperability, as three out of four note the need for reducing siloed data—and making their data more actionable—as the industry moves from a foundation of volume to value.

Many organizations are investing in a data lake to pull together and aggregate data from their many transactional systems. This requires a heavy investment in core data plumbing to establish data semantics that drive insights, and without this investment, the data lake can become a data swamp with significant challenges in driving organizational consistency in terminology and analytics stewardship.

Integrated solutions, consolidation, migration, and license termination of other vendor technologies offer strong opportunities for performance enhancement through decreased net IT spend and increased contextualization. One significant opportunity in this space is effective health cloud participation. When compared to internal efforts—with or without consultants—provider organizations save up to 80 percent in implementation time, and there is as much as a 75 percent decrease in costs to create and maintain.

Pillar 5: Workflow Efficiency

High-quality data management and processes (putting the right information in the right hands at the right time) increases productivity gains across teams. Such efforts help care coordination teams automate protocol assignment from admit, discharge, and transfer messages, eliminate time spent manipulating Excel sheets, and/or other key steps like pre-visit planning to review open gaps. Value levers within this final pillar include:

- Care coordination
- Analytics
- Call center operations
- Data ingestion
- Audit/reporting

Case Study: Increasing Efficiency and Saving Costs

PE, in the form of greater efficiency, lower costs, and increased output, is a critical need for operational leaders and managers—especially for today's challenges in staffing and retention, coupled with rising costs, regulation, and reporting requirements in VBC.

Utilizing recommended value levers in this pillar, a physician-led healthcare services organization increased care coordination team productivity and efficiency. In a year-over-year analysis of pre- and post-PEO efforts, the number of care protocols rendered, per full-time care coordinator, went from 565 to 643. This year-over-year 14 percent increase in productivity was realized through more efficient processes.

Performance Matters

Boards have ever-increasing responsibilities around making sure that their organizations are succeeding in financial, clinical, risk, and operation. Nowhere is this more important than within the shift and participation around risk-based programs in VBC. Success requires leverage, risk mitigation, greater levels of data readiness, and knowing where to make the right investments in infrastructure.

Performance is a major lynchpin for improving success in VBC—and PE plays a crucial role. PE, as a management-driven process, addresses value drivers of opportunity in non-optimized areas such as readmissions, network leakage, transitional care management, and much more.

Many boards face ever-shrinking operating margins, challenging requirements and leverage on payer contracts, provider burnout, and expectations around metrics and results—linked to payment. Management needs to identify, improve, and accurately report on the value-based "health" of an organization back to governance. PE drives better levels of data readiness and insights, which fuel greater guidance for organizations navigating their journey to value.

The Governance Institute thanks Brian Silverstein, M.D., Chief Population Health Officer, Innovaccer Inc., and Governance Institute Advisor, for contributing this article. He can be reached at brian.silverstein@innovaccer.com.

Performance Enhancement: An Essential Process for Provider Success and Sustainability

By Brian Silverstein, M.D., Innovaccer Inc.

As provider organizations move into greater levels of participation in value-based care (VBC), it is crucial they gauge the clinical and financial success of their investments in patient care, people, and processes—specific to performance related to risk-bearing contracts and reporting measurements.

Performance enhancement (PE) is the identification and quantification of high-level execution, related to contractual and operational key performance indicators, which demonstrates the value customers gain through improved contractual outcomes throughout the risk spectrum and operational efficiency. In today's VBC environment, those organizations that apply PE efforts to their administrative and clinical operations will have a greater opportunity to benefit in contract performance, including financial and quality of care.

PE efforts in provider organizations are driven, often successfully, through the application of performance enhancement opportunities (PEOs). These efforts work with the capabilities, protocols, and workflows of healthcare organizations and provide advanced insights. Provider organizations seeking PEOs can realize and capitalize upon PE applied through their own teams, as well as through consultants and vendors they hire.

The Healthcare System's Shift to Value-Based Care

The shift from fee-for-service (FFS) to VBC began back in April 2005 with the Medicare Physician Group Practice (PGP) Demonstration. After five years, the Affordable Care Act provided a stronger move to value by authorizing the Medicare Shared Savings Program (MSSP), which formally began in 2012. From that time until today, there have been additional efforts—and subsequent growth in payments related to value.

The COVID-19 pandemic has, in many ways, served as a catalyst, driving a sharp rise from a foundation of volume to value in care services and compensation. A study from HCPLAN, representing 238 million Americans or 80 percent of the covered population, shows that more than 60 percent of all healthcare dollars are now tied into some form of value-based reimbursement.[1] This includes models of population-based payments, shared risk, bundled payments, and shared savings. Moreover, many studies and surveys reflect greater success in clinical and administrative operations in VBC relating to those health organizations able to gain greater access to, use of, and generate crucial insights from data.

This is echoed by a November 2021 Guidehouse survey, where 36 percent of health system CFOs report the number one challenge around the adoption of VBC is their ability to transform data into actionable information.[2] Effective identification of PEOs should include solutions enabling healthcare data to be integrated, harmonized, normalized, and made actionable. This is where the PE process shines—in protocols linked to contractual, quality, and value drivers of VBC and pay-for-performance arrangements for providers.

Whether by choice, need, or both, as providers continue to transition from traditional FFS, they must intelligently straddle their transition to perform well in VBC agreements for future cost reduction shared savings, while driving appropriate present FFS revenue to the organization.

Successful employment of PE focuses on areas that matter in maximizing that value—including contract negotiation and reconciliation, appropriate risk coding, cost-of-care opportunities, quality performance, optimizing FFS utilization, network management, technical infrastructure, workflow efficiency, and more.

This article provides a proven five-pillar PE framework for management teams of provider organizations who seek to attain and sustain strong results—within growing levels of VBC—through PE and PEOs. These efforts also include crucial insights, which provides management with an ability to deliver accurate, timely, and insightful reporting, on a high level, to the board—related to the organization's performance within VBC.

Key Board Takeaways

- Ensure awareness and understanding of the healthcare organization's current levels of participation within programs and contracts involving VBC.
- Receive accurate and regular reporting on investments, expected outcomes, goals, and clinical as well as financial results of VBC participation.
- Know the strategy management uses to mitigate risk and meet and exceed performance metrics, related to success in VBC contracts and programs.
- Recognize that performance enhancement, by improving workflow efficiency, is linked to challenges in staffing and clinical team burnout.
- Ensure transparency to make sure that management has the right resources to manage success in current and growing levels of VBC involvement.
- Create guardrails for intervention, from the board to management, when red flags or poor results arise in select areas.

Performance Enhancement Opportunities: Driven by a Five-Pillar Framework

In the framework, there are five PE pillars, each supporting a group of underlying and specific value levers. When vendors utilize PE, the value levers of specific pillars are applied and run as recommended protocols in clinical and administrative efforts. This results in improving and optimizing specific workflows, monitoring and measuring results through standardized analyses and quarterly reviews, effective benchmarking to collaboratively build upon successes, as well as the shared contribution and development of best practices.

Pillar 1: VBC Operational Programs

In population health, avoidable events occur at a dynamic baseline within a cohort of patients. Strategic programs

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1 HCPLAN, *2020–2021 Methodology and Results Report.*
2 Guidehouse, *2021 Risk-Based Healthcare Market Trends.*